EXHIBIT A

Prudential

APPLICATION FOR LIFE INSURANCE

PART 1

☒ Pruco Life Insurance Company
☐ The Prudential Insurance Company of America
Both are Prudential Financial companies.
Corporate Offices, Newark, New Jersey

POLICY NUMBER (IF KNOWN): L9201428

A. PROPOSED INSURED (POLICY OWNER UNLESS SECTION D IS COMPLETED)

1. Name: SASIKALA NARRA
2. Previous name (if changed in the last 5 yrs.):
3. Social Security number: REDACTED 4. State of birth (Country if not U.S.): INDIA
5. Gender: ☒ Female ☐ Male 6. Date of birth REDACTED 1978 7. Date policy to Save Age? ☐ Yes ☒ No
8. Are you a permanent, legal US resident? ☒ Yes ☐ No
   If No, provide country of legal residence, type and number of visa, expiration date and length of US residence:
9. Driver's license issuing state: NJ Number REDACTED Expiration date: 08/12/2015
   If None, why not?:
10. Residence address (No PO boxes): Street HAMILTON ROAD Apt 3D
    City MAPLE SHADE State NJ ZIP 08052
11. e-mail address: HANUMANTHARAO.NARRA@GMAIL.COM
12. Home telephone number: (718) 496-5497 Business telephone number (ext.): (979) 691-7700
13. Current employer name: COGNIZANT TECHNOLOGIES
    Business address: Street 211 QUALITY CIR Suite
    City COLLEGE STATION State TX ZIP 77845
14. Occupation: SENIOR ASSOCIATE
    Duties: WORKING AS SYSTEM ANALYST AND MAKING DEVELOPMENT ACCORDING TO BUSINESS REQUIREMENTS
15. Earned annual income $ 94,000 Unearned annual income $ 0 Net worth $ 750,000

B. PLAN OF INSURANCE

1. Amount of insurance applied for: $ 500,000 **Complete *Financial Supplement* with face amounts of $5,000,000 or more up to age 70, $2,500,000 or more ages 71-80, $1,000,000 or more ages 81 and up.**
2. Product applied for:
   - ☒ Term Essential®: ☐ 10 ☐ 15 ☐ 20 ☒ 30
   - ☐ Term Elite®: ☐ 10 ☐ 15 ☐ 20 ☐ 30
   - ☐ ROP Term: ☐ 15 ☐ 20 ☐ 30
   - ☐ PruTerm WorkLife 65℠ (includes Insured's Waiver of Premium Benefit)
   - ☐ PruLife® Custom Premier II (PCP II) **Complete the *Variable Supplement.***
   - ☐ PruLife® Founders Plus (PFP) **Complete the *PFP Supplement.***
   - ☐ PruLife® Index Advantage (IAUL) **Complete the *IAUL Supplement.***
   - ☐ PruLife® Universal Plus (UL Plus)
   - ☐ PruLife® Universal Protector (UL Protector)
   - ☐ VUL Protector℠ (VULP) **Complete the *Variable Supplement.***
   - ☐ Other:
3. **For UL and VUL products only:** Death Benefit type: ☐ Type A (Level) ☐ Type B (Variable) – **N/A for UL Protector**
   ☐ Type C (Return of Premium) – **N/A for IAUL, UL Protector & VULP.** – Interest rate: %
4. **For UL and VUL products only:** Definition of life insurance:
   ☐ Cash Value Accumulation Test (CVAT) ☐ Guideline Premium Test (GPT)
5. Requested Optional Benefits: (Not all benefits are available for all products.):
   - ☐ Waiver of Premium/Enhanced Disability Benefit
   - ☒ Acceleration of Death Benefit (Living Needs Benefit)
   - ☐ Accidental Death Benefit: Amount $
   - ☐ BenefitAccess Rider **Complete *Benefit Access Rider Supplement.***
   - ☐ Overloan Protection Rider
   - ☐ Child Rider **Complete *Child Rider Supplement.***
   - ☐ Automatic Premium Loan
   - ☐ Enhanced Cash Value Rider
   - ☐ Other Riders/Benefits (indicate amount where applicable):

C. PREMIUM

1. Send notices (check one): ☒ Policyowner ☐ Other recipient:
   Send notices (check one): ☒ Policyowner's residence ☐ Other address:
   Street Apt
   City State ZIP
2. Premium payment mode: ☒ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly – Electronic Funds Transfer
3. **For non-term plans,** billed premium: $

D. OWNER (COMPLETE IF OWNER IS OTHER THAN THE PROPOSED INSURED)

For multiple owners, details are to be listed in Special Requests, section H.

1. Name of owner: ______
2. Social Security/Tax identification number (SSN/TIN): ______
3. Residence address (No PO boxes): Street ______ Apt ______
   City ______ State ______ ZIP ______
4. Owner's email address: ______

5a. For trust owner: **Complete the *Trustee Statement and Agreement* (COMB 86044).**
   Trust date: __/__/____
   Trustee(s) ______
   Type: ☐ Revocable ☐ Irrevocable ☐ Qualified Retirement Plan Trust ☐ Welfare Benefit Trust

5b. For business owner: **Complete the *Business Supplement*.**
   Form: ☐ Corporation ☐ Partnership ☐ Sole proprietorship ☐ Other: ______
   ☐ S Corporation ☐ LLC ☐ Tax exempt

5c. For personal owner:
   Total insurance program: Currently in-force: $______ Pending applications: $______
   Relationship to Proposed Insured: ______ Date of birth: __/__/____
   Earned annual income: $______ Unearned annual income: $______ Net worth: $______

E. BENEFICIARY DETAILS

If insurance is for business purposes, also complete the Business Insurance Supplement. If beneficiary is a trust, provide name of trust and trustee(s), date of trust and if trust is revocable or irrevocable. If beneficiary is a business, please list name of business, city and state where located and the form of business.

Name: First Middle Last	Relationship to Proposed Insured	Age	Beneficiary Class: Primary	Secondary/Contingent
SEE SPECIAL REQUESTS			☐	☐
			☐	☐
			☐	☐
			☐	☐

F. INSURANCE HISTORY

1. Do you have any existing life insurance or annuities? ☐ Yes ☒ No
   Note: Existing coverage includes any life insurance policies that have been assigned, sold or transferred.
2. Will this insurance replace* any existing insurance or annuity? ☐ Yes ☒ No
3. List the following details for all existing coverage. (List only annuities to be replaced*, list all in force life insurance):

Insurance Company	Face Amount	Type	Product	To Be Replaced?*	1035 Exchange?
	$	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No
	$	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No
	$	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No
	$	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No
	$	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No

*Replace or replaced means that the insurance being applied for may replace or cause a change in any existing insurance or annuity with any company, including the lapse or surrender of the existing policy, or the use of funds or values from the existing policy to pay for the new policy.

4. Are you applying for or reinstating life insurance with any company? ☐ Yes ☒ No
   If Yes, give company name, amount applied for and total amount to be placed, including this application :
   ______
   ______
5. Have you had life or health insurance declined, postponed, rated or issued with an increased premium? ☐ Yes ☒ No
   If Yes, give company name, type of insurance, date, action taken and reason for action :
   ______
   ______

(CONTINUED)

F. INSURANCE HISTORY (CONTINUED)

6. Is the proposed insured or proposed owner considering the transfer or sale to a life settlement company or other investor of: policy ownership; or, any interest in the policy benefits, either directly as a named beneficiary or indirectly as a beneficiary or owner of a trust or other entity? ☐ Yes ☒ No

If Yes, provide details : _____

G. GENERAL INFORMATION

1. In the past five years, have you flown as a pilot, student pilot or crew member or do you intend to become a pilot? ☐ Yes ☒ No
2. In the past five years, have you participated in any activities such as motorized vehicle racing, SCUBA diving, mountain climbing, skydiving, extreme sports such as BASE jumping, bungee jumping or cave exploration, or do you intend to? ☐ Yes ☒ No

If Yes, to Question 1 or 2 above, complete the appropriate Supplement.

3. Have you ever used tobacco or any other nicotine products such as cigarettes, cigars, pipe, chewing tobacco, snuff, nicotine gum or nicotine patch? ***If Yes, provide details :*** ☐ Yes ☒ No

Product Type(s)	Date Last Used	Frequency of Use

4. In the past five years, have you.
   a. had your driver's license denied, suspended or revoked? ☐ Yes ☒ No
   b. been convicted of or pled guilty to driving under the influence of alcohol and/or drugs? ☐ Yes ☒ No
   c. been convicted of or pled guilty to any moving violations? ☐ Yes ☒ No
5. Within the past 10 years, have you been arrested, convicted, or imprisoned for any crime and/or are you currently awaiting trial for any crime? ☐ Yes ☒ No
6. Will you live or travel outside the United States within the next 12 months? ☐ Yes ☒ No

Details required include location (city/country), frequency, duration and purpose of each trip.

7. Give complete details of any "Yes" answers for questions 4 – 6, including question number and appropriate details:

Question #	Details

H. SPECIAL REQUESTS

(Class 1) - HANUMANTHARAO NARRA , HUSBAND , 36 ;(Class 2) - CHILDREN OF THE INSURED IN EQUAL SHARES OR TO THE SURVIVOR(S)

PART 2

A. PERSONAL PHYSICIAN INFORMATION

Name SURENDRA SHETH

Address: Street 526 LIPPINCOTT DR Suite

City MARLTON State NJ ZIP 08053

Telephone number: (856) 985-3700 Date last seen: 09/2014

Reason last seen: GENERAL CHECK UP

If more than one personal physician, provide details in section D number 6.

B. PHYSICAL MEASUREMENTS

1. Height: 5 feet 4 inches Weight: 176 pounds
2. Within the last 12 months, have you had a change of weight (gain or loss) of more than 10 pounds? ☐ Yes ☒ No
   If Yes, provide details:

C. FAMILY HISTORY

1. Have any immediate family members (mother, father, brother, sister) been diagnosed with or died from coronary artery disease, cerebrovascular disease, diabetes or cancer before age 70? ☐ Yes ☒ No
   If Yes, provide details including which member and medical condition, age at diagnosis, and age at death (if applicable):
2. **Father:** Current age 64 or Age at death: **Mother:** Current age 62 or Age at death:

D. MEDICAL INFORMATION

1. Has a member of the medical profession ever treated you for or diagnosed you with:
   a. high blood pressure, chest pain, a heart attack, coronary artery disease, a heart valve disorder, a heart murmur, an irregular heart beat, cerebrovascular disease, a stroke, circulatory disease, an aneurysm or any disease of the heart or blood vessels? ☐ Yes ☒ No
   b. anemia or other abnormality of the blood (other than HIV)? ☐ Yes ☒ No
   c. a polyp, cyst, tumor, cancer, leukemia, melanoma, lymphoma or Hodgkin's disease? ☐ Yes ☒ No
   d. diabetes, high blood sugar, glucose intolerance or other endocrine disorder? ☐ Yes ☒ No
   e. anxiety, depression, or any other mental or psychiatric illness? ☐ Yes ☒ No
   f. Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any other sexually transmitted disease (other than HIV)? ☐ Yes ☒ No
   g. asthma, emphysema, cystic fibrosis, sleep apnea, sarcoidosis, tuberculosis or any other disorder of the lungs or respiratory system? ☐ Yes ☒ No
   h. a seizure, epilepsy, multiple sclerosis, Parkinson's disease, muscular dystrophy, cerebral palsy, paralysis, Alzheimer's disease or any other disorder of the brain or nervous system? ☐ Yes ☒ No
   i. an ulcer, hepatitis, cirrhosis, pancreatitis, ulcerative colitis, Crohn's disease or any other disorder of the esophagus, liver, stomach or intestines? ☐ Yes ☒ No
   j. nephritis, polycystic kidney disease or any other disorder of the bladder, kidney, urinary tract or prostate? ☐ Yes ☒ No
   k. arthritis, gout, back trouble, or any disease or disorder of the joints, muscles or bones? ☐ Yes ☒ No
   l. lupus, rheumatoid arthritis, chronic fatigue syndrome, fibromyalgia, or any other disease or disorder of the autoimmune system? ☐ Yes ☒ No
2. Have you ever used:
   a. cocaine, crack, marijuana, heroin, Ecstasy, PCP, LSD, methamphetamine, any other hallucinogenic drug or controlled substance? ☐ Yes ☒ No
   b. amphetamines, barbiturates, sedatives, opiates or methadone, or controlled substance except as prescribed by a physician? ☐ Yes ☒ No
3. Have you had or been advised to have treatment or counseling for alcohol or drug use or been asked to reduce or eliminate their usage? ☐ Yes ☒ No
4. Other than what has already been disclosed, within the past 5 years, have you:
   a. requested or received disability or compensation benefits? ☐ Yes ☒ No
   b. been a patient in a hospital or other medical facility, other than for normal childbirth? ☐ Yes ☒ No
   c. had any other disease, disorder or condition? ☐ Yes ☒ No
   d. been advised to have surgery, medical tests or diagnostic procedures (other than for HIV)? ☐ Yes ☒ No
5. Are you currently receiving medical treatment or taking any other medication or herbal supplement that has not already been disclosed? ☐ Yes ☒ No

(CONTINUED)

D. MEDICAL INFORMATION (CONTINUED)

6. Give complete details of any "Yes" answers for questions 1-5, including: **Question number, diagnosis, date of onset and recovery, medication/treatment prescribed and the name, address and telephone number of all attending physicians and hospitals.**

Question #	Diagnosis	Date of Onset	Date of Recovery	Medication/ Treatment Prescribed	Physician/Hospital Name, Address & Phone Number

AGREEMENTS

By signing this form, I have carefully reviewed the application including all supplements attached to the policy, and I agree to the following:

- To the best of my knowledge and belief, the statements in this application are complete, true and correctly recorded.
- Except for failure to pay premium, the validity of this policy will not be contested after it has been in force during the insured's lifetime for two years from the date it takes effect.
- If I have requested the Acceleration of Death Benefits (Living Needs Benefit), I have read the disclosures in the Living Needs Benefit brochure.
- My original signature has been affixed to this application, the original will be retained by the Company named at the beginning of this application ("Company"). The copies attached to the policy issued to me are identical in form and substance.
- Any policy issued on this application shall not take effect until after all of the following conditions are met:
  - A payment equal to the full first required premium is received by the Company within the lifetime of the proposed insured. A payment will only be considered to be received if one of the following valid items is received by the Company: (i) a check in the amount of the full first required premium; (ii) a completed and signed payment form for the first full premium; or (iii) any other form of payment acceptable to the Company.
  - The form of payment submitted is honored. If payment is made by credit/debit card, wire transfer or automatic bank draft, no premium is considered to be honored until the Company actually receives the funds unless otherwise provided by applicable law.
  - A signed copy of this Application is received by the Company.
  - The Owner has personally received the policy during the lifetime of and while the health of the Proposed Insured is as stated in this application.
- Only an officer of the Company with the rank or title of Vice President may make or alter any contract or agree not to enforce any of the rights of the Company, and then only in writing. **No producer or medical examiner is authorized to accept risks, pass on insurability, make or alter contracts, or waive any of the other rights or requirements of the Company.** Notice to or knowledge imputed to any producer or medical examiner will not be notice of or knowledge to the Company unless it is set out in writing in this application.

FRAUD WARNING

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

SIGNATURES

Owner's Tax Certification (check boxes **ONLY** if applicable):

Under penalties of perjury, I certify that the taxpayer identification number (TIN) I have listed on this form is my correct TIN. I further certify that I am a U.S. person (including resident alien), and I am not subject to backup withholding under Section 3406(a)(1)(C) of the Internal Revenue Code.

☐ I have been notified by the Internal Revenue Service that I am subject to backup withholding due to the underreporting of interest or dividends

☐ I am not a U.S. person (including resident alien). You must submit the applicable Form W-8 (BEN, BEN-E, ECI, EXP or IMY). In most cases, Form W-8BEN will be the appropriate form.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Signed at (STATE) NEW JERSEY on (DATE) 09/03/15

➔ Signature of proposed insured X Santos

If policyowner is different from the proposed insured:

For a personal policyowner(s):

➔ Signature of policyowner(s) X _____

For an entity policyowner(s) (i.e., trust, business):

Name of entity _____

➔ Signature of officer/trustee(s) X _____

Title of officer/trustee(s) _____

➔ **Signature of producer** X _____

EXHIBIT B

Prudential

APPLICATION FOR LIFE INSURANCE

PART 1

☒ Pruco Life Insurance Company
☐ The Prudential Insurance Company of America
Both are Prudential Financial companies.
Corporate Offices, Newark, New Jersey

POLICY NUMBER (IF KNOWN): V2353442

A. PROPOSED INSURED (POLICY OWNER UNLESS SECTION D IS COMPLETED)

1. Name: SASIKALA NARRA
2. Previous name (if changed in the last 5 yrs.):
3. Social Security numb REDACTED — State of birth (Country if not U.S.): INDIA
5. Gender: ☒Female ☐Male 6. Date of birth REDACTED 1978 7. Date policy to Save Age? ☐Yes ☒No
8. Are you a permanent, legal US resident? ☒Yes ☐No
   If No, provide country of legal residence, type and number of visa, expiration date and length of US residence:
9. Driver's license issuing state: NJ Number: REDACTED Expiration date: 08/12/2015
   If None, why not?:
10. Residence address (No PO boxes): Street HAMILTON ROAD Apt 3D
    City MAPLE SHADE State NJ ZIP 08052
11. e-mail address: HANUMANTHARAO.NARRA@GMAIL.COM
12. Home telephone number: (718) 496-5497 Business telephone number (ext.): (979) 691-7700
13. Current employer name: COGNIZANT TECHNOLOGIES
    Business address: Street 211 QUALITY CIR Suite
    City COLLEGE STATION State TX ZIP 77845
14. Occupation: SENIOR ASSOCIATE
    Duties: WORKING AS SYSTEM ANALYST AND MAKING DEVELOPMENT ACCORDING TO BUSINESS REQUIREMENTS
15. Earned annual income $ 94,000 Unearned annual income $ 0 Net worth $ 750,000

B. PLAN OF INSURANCE

1. Amount of insurance applied for: $ 500,000 **Complete *Financial Supplement* with face amounts of $5,000,000 or more up to age 70, $2,500,000 or more ages 71-80, $1,000,000 or more ages 81 and up.**
2. Product applied for:
   - ☐ Term Essential®: ☐10 ☐15 ☐20 ☐30
   - ☐ Term Elite®: ☐10 ☐15 ☐20 ☐30
   - ☐ ROP Term: ☐15 ☐20 ☐30
   - ☐ PruTerm WorkLife 65℠ (includes Insured's Waiver of Premium Benefit)
   - ☐ PruLife® Custom Premier II (PCP II) **Complete the *Variable Supplement.***
   - ☐ PruLife® Founders Plus (PFP) **Complete the *PFP Supplement.***
   - ☐ PruLife® Index Advantage (IAUL) **Complete the *IAUL Supplement.***
   - ☐ PruLife® Universal Plus (UL Plus)
   - ☒ PruLife® Universal Protector (UL Protector)
   - ☐ VUL Protector℠ (VULP) **Complete the *Variable Supplement.***
   - ☐ Other:
3. For **UL and VUL products only**: Death Benefit type: ☒ Type A (Level) ☐ Type B (Variable) – **N/A for UL Protector**
   ☐ Type C (Return of Premium) – **N/A for IAUL, UL Protector & VULP.** – Interest rate: %
4. For **UL and VUL products only**: Definition of life insurance:
   ☒ Cash Value Accumulation Test (CVAT) ☐ Guideline Premium Test (GPT)
5. Requested Optional Benefits: (Not all benefits are available for all products.):
   - ☐ Waiver of Premium/Enhanced Disability Benefit
   - ☐ Acceleration of Death Benefit (Living Needs Benefit)
   - ☐ Accidental Death Benefit: Amount $
   - ☒ BenefitAccess Rider **Complete *Benefit Access Rider Supplement.***
   - ☐ Other Riders/Benefits (indicate amount where applicable):
   - ☐ Overloan Protection Rider
   - ☐ Child Rider **Complete *Child Rider Supplement.***
   - ☐ Automatic Premium Loan
   - ☐ Enhanced Cash Value Rider

C. PREMIUM

1. Send notices (check one): ☒ Policyowner ☐ Other recipient:
   Send notices (check one): ☒ Policyowner's residence ☐ Other address:
   Street Apt
   City State ZIP
2. Premium payment mode: ☐ Annual ☐ Semiannual ☐ Quarterly ☒ Monthly – Electronic Funds Transfer
3. **For non-term plans,** billed premium: $ 248.00

D. OWNER (COMPLETE IF OWNER IS OTHER THAN THE PROPOSED INSURED)

For multiple owners, details are to be listed in Special Requests, section H.

1. Name of owner: ______
2. Social Security/Tax identification number (SSN/TIN): ______
3. Residence address (No PO boxes): Street ______ Apt ______
   City ______ State ______ ZIP ______
4. Owner's email address: ______

5a. For trust owner: **Complete the *Trustee Statement and Agreement* (COMB 86044).**
   Trust date: ___/___/______
   Trustee(s) ______
   Type: ☐ Revocable ☐ Irrevocable ☐ Qualified Retirement Plan Trust ☐ Welfare Benefit Trust

5b. For business owner: **Complete the *Business Supplement*.**
   Form: ☐ Corporation ☐ Partnership ☐ Sole proprietorship ☐ Other: ______
   ☐ S Corporation ☐ LLC ☐ Tax exempt

5c. For personal owner:
   Total insurance program: Currently in-force: $______ Pending applications: $______
   Relationship to Proposed Insured: ______ Date of birth: ___/___/______
   Earned annual income: $______ Unearned annual income: $______ Net worth: $______

E. BENEFICIARY DETAILS

If insurance is for business purposes, also complete the Business Insurance Supplement. If beneficiary is a trust, provide name of trust and trustee(s), date of trust and if trust is revocable or irrevocable. If beneficiary is a business, please list name of business, city and state where located and the form of business.

Name: First	Middle	Last	Relationship to Proposed Insured	Age	Beneficiary Class: Primary	Secondary/Contingent
SEE SPECIAL REQUESTS					☐	☐
					☐	☐
					☐	☐
					☐	☐

F. INSURANCE HISTORY

1. Do you have any existing life insurance or annuities? ☐ Yes ☒ No
   Note: Existing coverage includes any life insurance policies that have been assigned, sold or transferred.
2. Will this insurance replace* any existing insurance or annuity? ☐ Yes ☒ No
3. List the following details for all existing coverage. (List only annuities to be replaced*, list all in force life insurance):

Insurance Company	Face Amount	Type	Product	To Be Replaced?*	1035 Exchange?
	$	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No
	$	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No
	$	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No
	$	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No
	$	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No

*Replace or replaced means that the insurance being applied for may replace or cause a change in any existing insurance or annuity with any company, including the lapse or surrender of the existing policy, or the use of funds or values from the existing policy to pay for the new policy.

4. Are you applying for or reinstating life insurance with any company? ☐ Yes ☒ No
   ***If Yes, give company name, amount applied for and total amount to be placed, including this application*:**
   ______
   ______
5. Have you had life or health insurance declined, postponed, rated or issued with an increased premium? ☐ Yes ☒ No
   ***If Yes, give company name, type of insurance, date, action taken and reason for action*:**
   ______
   ______

(CONTINUED)

F. INSURANCE HISTORY (CONTINUED)

6. Is the proposed insured or proposed owner considering the transfer or sale to a life settlement company or other investor of: policy ownership; or, any interest in the policy benefits, either directly as a named beneficiary or indirectly as a beneficiary or owner of a trust or other entity? ☐ Yes ☒ No

If Yes, provide details : _____

G. GENERAL INFORMATION

1. In the past five years, have you flown as a pilot, student pilot or crew member or do you intend to become a pilot? ☐ Yes ☒ No
2. In the past five years, have you participated in any activities such as motorized vehicle racing, SCUBA diving, mountain climbing, skydiving, extreme sports such as BASE jumping, bungee jumping or cave exploration, or do you intend to? ☐ Yes ☒ No

   If Yes, to Question 1 or 2 above, complete the appropriate Supplement.
3. Have you ever used tobacco or any other nicotine products such as cigarettes, cigars, pipe, chewing tobacco, snuff, nicotine gum or nicotine patch? ***If Yes, provide details :*** ☐ Yes ☒ No

Product Type(s)	Date Last Used	Frequency of Use

4. In the past five years, have you:
   a. had your driver's license denied, suspended or revoked? ☐ Yes ☒ No
   b. been convicted of or pled guilty to driving under the influence of alcohol and/or drugs? ☐ Yes ☒ No
   c. been convicted of or pled guilty to any moving violations? ☐ Yes ☒ No
5. Within the past 10 years, have you been arrested, convicted, or imprisoned for any crime and/or are you currently awaiting trial for any crime? ☐ Yes ☒ No
6. Will you live or travel outside the United States within the next 12 months? ☐ Yes ☒ No

   Details required include location (city/country), frequency, duration and purpose of each trip.
7. Give complete details of any "Yes" answers for questions 4 – 6, including question number and appropriate details:

   Question # Details

H. SPECIAL REQUESTS

NO LAPSE GUARANTEE REQUESTED. (Class 1) - HANUMANTHARAO NARRA , HUSBAND , 36 ;(Class 2) - CHILDREN OF THE INSURED IN EQUAL SHARES OR TO THE SURVIVOR(S)

Prudential

BENEFITACCESS RIDER SUPPLEMENT

Supplementary Declarations Forming a Part of the Application For Insurance

Pruco Life Insurance Company
a Prudential Financial company

POLICY NUMBER (IF KNOWN): V2353442

PRIMARY PROPOSED INSURED: SASIKALA NARRA

A. MEDICAL HISTORY

1. Has a member of the medical profession ever treated you for or diagnosed you with:
   a. amyotrophic lateral sclerosis (ALS, Lou Gehrig's Disease), Huntington's chorea, ataxia, transverse myelitis or myasthenia gravis? ☐ Yes ☒ No
   b. chronic, recurrent, or persistent memory loss or confusion; senility, cognitive impairment, dementia or organic brain disease? ☐ Yes ☒ No
   c. amputation of more than one limb? ☐ Yes ☒ No
   d. more than one transient ischemic attack (TIA, mini stroke)? ☐ Yes ☒ No
   e. osteoporosis with compression fracture(s) or other related fracture(s), post polio syndrome or chronic pain syndrome? ☐ Yes ☒ No

2. Within the past 2 years, have you:
   a. been advised by a member of the medical profession to discontinue the driving of an automobile? ☐ Yes ☒ No
   b. fallen more than once, been in a long term care facility, nursing home, required the services of a home health care provider, or attended adult day care? ☐ Yes ☒ No
   c. been declined for long term care insurance including coverage offered as a rider to a life insurance or other policy? ☐ Yes ☒ No

3. Do you currently:
   a. need, or have you been advised to receive, help or supervision with personal hygiene, toilet use, eating, taking medication, getting in or out of a bed or chair, walking, dressing or bathing? ☐ Yes ☒ No
   b. use a wheelchair, motorized scooter, walker, quad cane, stairlift, oxygen, respirator, catheter or dialysis machine? ☐ Yes ☒ No
   c. need help or supervision with laundry, cleaning, shopping, using the telephone, meal preparation, managing finances, managing your medication, use of transportation or yard work? ☐ Yes ☒ No
   d. receive any long term care benefits? ☐ Yes ☒ No
   e. have or have you applied for a handicap placard or handicap license plate? ☐ Yes ☒ No

Give complete details of any "Yes" answer(s) to questions 1-3 including: **Question number, diagnosis/condition, date, treatment, and the name, address and telephone number of all attending physicians and hospitals.**

Question #	Diagnosis/Condition	Date	Treatment	Physician/Hospital Name, Address & Phone Number

PART 2

A. PERSONAL PHYSICIAN INFORMATION

Name SURENDRA SHETH

Address: Street 526 LIPPINCOTT DR Suite

City MARLTON State NJ ZIP 08053

Telephone number: (856) 985-3700 Date last seen: 09/2014

Reason last seen: GENERAL CHECK UP

If more than one personal physician, provide details in section D number 6.

B. PHYSICAL MEASUREMENTS

1. Height: 5 feet 4 inches Weight: 176 pounds
2. Within the last 12 months, have you had a change of weight (gain or loss) of more than 10 pounds? ☐ Yes ☒ No
   If Yes, provide details :

C. FAMILY HISTORY

1. Have any immediate family members (mother, father, brother, sister) been diagnosed with or died from coronary artery disease, cerebrovascular disease, diabetes or cancer before age 70? ☐ Yes ☒ No
   If Yes, provide details including which member and medical condition, age at diagnosis, and age at death (if applicable) :
2. **Father:** Current age 64 or Age at death: **Mother:** Current age 62 or Age at death:

D. MEDICAL INFORMATION

1. Has a member of the medical profession ever treated you for or diagnosed you with:
   a. high blood pressure, chest pain, a heart attack, coronary artery disease, a heart valve disorder, a heart murmur, an irregular heart beat, cerebrovascular disease, a stroke, circulatory disease, an aneurysm or any disease of the heart or blood vessels? ☐ Yes ☒ No
   b. anemia or other abnormality of the blood (other than HIV)? ☐ Yes ☒ No
   c. a polyp, cyst, tumor, cancer, leukemia, melanoma, lymphoma or Hodgkin's disease? ☐ Yes ☒ No
   d. diabetes, high blood sugar, glucose intolerance or other endocrine disorder? ☐ Yes ☒ No
   e. anxiety, depression, or any other mental or psychiatric illness? ☐ Yes ☒ No
   f. Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any other sexually transmitted disease (other than HIV)? ☐ Yes ☒ No
   g. asthma, emphysema, cystic fibrosis, sleep apnea, sarcoidosis, tuberculosis or any other disorder of the lungs or respiratory system? ☐ Yes ☒ No
   h. a seizure, epilepsy, multiple sclerosis, Parkinson's disease, muscular dystrophy, cerebral palsy, paralysis, Alzheimer's disease or any other disorder of the brain or nervous system? ☐ Yes ☒ No
   i. an ulcer, hepatitis, cirrhosis, pancreatitis, ulcerative colitis, Crohn's disease or any other disorder of the esophagus, liver, stomach or intestines? ☐ Yes ☒ No
   j. nephritis, polycystic kidney disease or any other disorder of the bladder, kidney, urinary tract or prostate? ☐ Yes ☒ No
   k. arthritis, gout, back trouble, or any disease or disorder of the joints, muscles or bones? ☐ Yes ☒ No
   l. lupus, rheumatoid arthritis, chronic fatigue syndrome, fibromyalgia, or any other disease or disorder of the autoimmune system? ☐ Yes ☒ No
2. Have you ever used:
   a. cocaine, crack, marijuana, heroin, Ecstasy, PCP, LSD, methamphetamine, any other hallucinogenic drug or controlled substance? ☐ Yes ☒ No
   b. amphetamines, barbiturates, sedatives, opiates or methadone, or controlled substance except as prescribed by a physician? ☐ Yes ☒ No
3. Have you had or been advised to have treatment or counseling for alcohol or drug use or been asked to reduce or eliminate their usage? ☐ Yes ☒ No
4. Other than what has already been disclosed, within the past 5 years, have you:
   a. requested or received disability or compensation benefits? ☐ Yes ☒ No
   b. been a patient in a hospital or other medical facility, other than for normal childbirth? ☐ Yes ☒ No
   c. had any other disease, disorder or condition? ☐ Yes ☒ No
   d. been advised to have surgery, medical tests or diagnostic procedures (other than for HIV)? ☐ Yes ☒ No
5. Are you currently receiving medical treatment or taking any other medication or herbal supplement that has not already been disclosed? ☐ Yes ☒ No

(CONTINUED)

D. MEDICAL INFORMATION (CONTINUED)

6. Give complete details of any "Yes" answers for questions 1-5, including: **Question number, diagnosis, date of onset and recovery, medication/treatment prescribed and the name, address and telephone number of all attending physicians and hospitals.**

Question #	Diagnosis	Date of Onset	Date of Recovery	Medication/ Treatment Prescribed	Physician/Hospital Name, Address & Phone Number

AGREEMENTS

By signing this form, I have carefully reviewed the application including all supplements attached to the policy, and I agree to the following:

- To the best of my knowledge and belief, the statements in this application are complete, true and correctly recorded.
- Except for failure to pay premium, the validity of this policy will not be contested after it has been in force during the insured's lifetime for two years from the date it takes effect.
- If I have requested the Acceleration of Death Benefits (Living Needs Benefit), I have read the disclosures in the Living Needs Benefit brochure.
- My original signature has been affixed to this application, the original will be retained by the Company named at the beginning of this application ("Company"). The copies attached to the policy issued to me are identical in form and substance
- Any policy issued on this application shall not take effect until after all of the following conditions are met.
  - A payment equal to the full first required premium is received by the Company within the lifetime of the proposed insured. A payment will only be considered to be received if one of the following valid items is received by the Company: (i) a check in the amount of the full first required premium; (ii) a completed and signed payment form for the first full premium; or (iii) any other form of payment acceptable to the Company.
  - The form of payment submitted is honored. If payment is made by credit/debit card, wire transfer or automatic bank draft, no premium is considered to be honored until the Company actually receives the funds unless otherwise provided by applicable law.
  - A signed copy of this Application is received by the Company.
  - The Owner has personally received the policy during the lifetime of and while the health of the Proposed Insured is as stated in this application.
- Only an officer of the Company with the rank or title of Vice President may make or alter any contract or agree not to enforce any of the rights of the Company, and then only in writing. **No producer or medical examiner is authorized to accept risks, pass on insurability, make or alter contracts, or waive any of the other rights or requirements of the Company.** Notice to or knowledge imputed to any producer or medical examiner will not be notice of or knowledge to the Company unless it is set out in writing in this application.

FRAUD WARNING

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

SIGNATURES

Owner's Tax Certification (check boxes **ONLY** if applicable):

Under penalties of perjury, I certify that the taxpayer identification number (TIN) I have listed on this form is my correct TIN. I further certify that I am a U.S. person (including resident alien), and I am not subject to backup withholding under Section 3406(a)(1)(C) of the Internal Revenue Code.

☐ I have been notified by the Internal Revenue Service that I am subject to backup withholding due to the underreporting of interest or dividends

☐ I am not a U.S. person (including resident alien). You must submit the applicable Form W-8 (BEN, BEN-E, ECI, EXP or IMY). In most cases, Form W-8BEN will be the appropriate form.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Signed at (STATE) ***NEW JERSEY*** on (DATE) 09/02/15

➔ Signature of proposed insured X [signature]

If policyowner is different from the proposed insured:

For a personal policyowner(s):

➔ Signature of policyowner(s) X _____

For an entity policyowner(s) (i.e., trust, business):

Name of entity _____

➔ Signature of officer/trustee(s) X _____

Title of officer/trustee(s) _____

➔ **Signature of producer** X [signature]

EXHIBIT C

STATE OF NEW JERSEY

NEW JERSEY DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

B00089271 66

STATE FILE NUMBER 20170018474

1a. Legal Name of Decedent (First, Middle, Last, Suffix): Sasikala Narra

LIMB ONLY

1b. Also Known As (AKA), If Any (First, Middle, Last, Suffix):

2. Sex	3. Social Security Number	4a. Age	5. Date of Birth (Mo/Day/Yr)
Female	REDACTE	38 Years	REDA 978

6. Birthplace (City & State/Foreign Country): Vijayawada, Andhra Pradesh, India

7a. Residence-State	7b. County	7c. Municipality/City	
New Jersey	Burlington	Maple Shade Township	
7d. Street and Number: 3 Hamilton Road	7e. Apt No: D	7f. Zip Code: 08052	7g. Inside City Limits? Yes

8a. Ever in US Armed Forces?	8b. If Yes, Name of War	8c. War Service Dates (From/To)
No		

9. Domestic Status at Time of Death	10. Name of Surviving Spouse/Partner (Name given at birth or on birth certificate)
Married	Hanumantharao Narra

11. Father's Name (First, Middle, Last): Venkateswarao Sankara

12. Mother's Name Prior to First Marriage (First, Middle, Last): Krishna Kumari Kolli

13a. Name of Informant	13b. Relationship to Decedent
Hanumantharao Narra	Spouse

13c. Mailing Address (Street and Number, City, State, Zip Code): 3 Hamilton Road Apt. D, Maple Shade, NJ 08052

14. Method of Disposition	15. Place of Disposition (name of cemetery, crematory, other)	16. Location- City & State/Foreign Country
Removal from State	Hyderabad Crematory	Hyderabad, India

17. Name and Complete Address of Funeral Facility: The Hindu Funeral Home, 78 Woodbridge Avenue, Highland Park, NJ 08904

18. Electronic Signature of Funeral Director	19. NJ License Number
Alexandria E Freeman	23JF00507800

20. Decedent Education	21. Decedent of Hispanic Origin?	22. Decedent Race
Master's degree (MA, MS, MEng, Med, MSW, MBA)	Not Spanish / Hispanic / Latino	Sought but unknown

23. Occupation of Decedent (Type of work done most of life, even if retired)	24. Kind of Business/Industry
Software Engineer	Information Technology

25. Name and Address of Last Employer: Cognizant Technologies, 211 Quality Circle , College Station, TX 77845

26. Date Pronounced Dead (Mo/Day/Yr)	28. Name of Person Pronouncing Death
03/23/2017	Kevin T Dwyer

27. Time Pronounced Dead (24-hr)	29. License Number	30. Date Signed (Mo/Day/Yr)
2124	25MB09883400	03/24/2017

31. Date of Death (Mo/Day/Yr)	32. Time of Death (24-hr)	33. Was Medical Examiner Contacted?	34. Place of Death
03/23/2017	Approx-1530	Yes	Decedent's Home

35a. Facility Name (If not institution, give street and number): 3D Hamilton Rd

35b. Municipality	35c. County
Maple Shade Township	Burlington

CAUSE OF DEATH

36a. PART I - IMMEDIATE CAUSE - final disease or condition resulting in death. Subsequently list conditions, if any, leading to the cause listed on Line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST.

		Interval Between Onset and Death
Immediate Cause	a SLASH WOUND OF NECK	few minutes
Due to (or as a consequence of):	b	
Due to (or as a consequence of)	c	
Due to (or as a consequence of)	d	

36b. PART II - Enter other significant conditions contributing to death but not resulting in underlying cause given in PART I

37. Was an Autopsy Performed?	38. Were Autopsy Findings Available to Complete Cause of Death?
Yes	Yes

39. Date of Injury (Mo/Day/Yr)	40. Time of Injury (24-hr)	41. Place of Injury (e.g. home, construction site, restaurant)	42. Injury at Work?
03/23/2017	Unknown	Residence	No

43a. Location of Injury (Number and Street, Zip Code)	43b. Municipality	43c. County	43d. State
3D Hamilton Rd 08052	Maple Shade Township	Burlington	NJ

44. Describe How Injury Occurred	45. If Transportation Injury
Stabbed stashed and bludgeoned by other(s)	Not Applicable

46. Manner of Death	47. Did Decedent Have Diabetes?	48. Did Tobacco Use Contribute to Death?	49. If Female, Pregnancy State
Homicide	No	No	Unknown

50. Certifier Type	51. Name, Address, and Zip Code of Certifier
Medical Examiner	Ian C Hood, M.D. 4 Academy Drive, Westampton, NJ 08060

52. Electronic Signature of Certifier	53. License Number	54. Date Certified (Mo/Day/Yr)
Ian C Hood	25MA05987100	03/24/2017

55. Electronic Signature of Local Registrar	56. District No	57. Date Received	Case ID Number
Jennifer Santiago	V1221	03/28/2017	1906292

Record Contains Amendment ☐

DATE ISSUED: **March 28, 2017**

ISSUED BY:
Highland Park Borough
Joan Hullings, Local Registrar

This is to certify that the above is correctly copied from a record on file in my office.
Certified copy not valid unless the raised Great Seal of the State of New Jersey or the seal of the issuing municipality or county, is affixed hereon.

Vincent T. Arrisi
State Registrar
Office of Vital Statistics and Registry

MAY 80[illegible]

REG-42B
JUN 14

THIS DOCUMENT HAS MULTIPLE SECURITY FEATURES TO DETER FRAUD: VOID IF ALTERED

THIS DOCUMENT CONTAINS A UNIQUE STATE OF NJ WATERMARK HOLD AT LIGHT TO VERIFY

THIS DOCUMENT CONTAINS A UNIQUE STATE OF NJ WATERMARK HOLD AT LIGHT TO VERIFY

EXHIBIT D

http://www.indiawest.com/news/global_indian/k-reward-offered-for-information-about-new-jersey-software-engineer/article_97660cc8-942d-11e7-a559-1b610c0c2563.html

FEATURED

$25K Reward Offered for Information About New Jersey Software Engineer Sasikala Narra's Murder

SUNITA SOHRABJI, India-West Staff Reporter Sep 8, 2017

A $25,000 reward has been offered for information about the murder of Indian American software engineer Sasikala Narra, who was found dead last March in her Maple Shade, New Jersey, apartment, alongside her six-year old son, /RED "We're hoping that this would be an incentive for someone to come forward with information," Joel Bewley, spokesman for the Burlington County, New Jersey prosecutor's office, told **India-West**. (Burlington County Prosecutor's Office photo)

A $25,000 reward has been offered for information leading to the arrest and conviction of persons involved in the murder of Indian American software engineer Sasikala Narra and her six-year-old son, A RED ACTE who were found dead in their Maple Shade, New Jersey, apartment on March 23.

Narra, 38, and A REDA CTED were found slain in the bedroom of their home by Narra's husband, Hanumantha Rao. Both mother and son had been stabbed multiple times, Joel Bewley, spokesman for the Burlington County, New Jersey Prosecutor's Office, told **India-West**.

"We're hoping that this reward would be an incentive for someone to come forward with information," said Bewley, noting that the investigation was "very active and ongoing." Police have been going door to door in the community where Narra and her husband Hanumantha Rao lived with their son, passing out flyers offering the reward printed in Hindi, Telugu, Spanish, and English.

Bewley thanked the Indian Cultural Center in Evesham, New Jersey, for helping to translate the flyers into Hindi and Telugu.

Rao found the bodies of his wife and son on the evening of the murder, and called 911. He told dispatchers he did not know what had happened, as he had just returned home after "happy hour" after work with some of his co-workers from Cognizant.

Questioned by detectives, Rao said he could not remember whether he had used his key to get into the apartment, a key question in the case which would determine whether there was breaking and entering into the apartment.

In the 911 call released by Maple Shade police, an unidentified woman's voice can be heard in the background. When the 911 dispatcher asked Rao if he could perform CPR on his wife and child, the woman screamed: "No you can't. Their throats are slit."

She can also be heard on the recording telling Rao: "Don't go back in there."

Rao was believed to have been having an affair with Deepa Ajit, who also works at Cognizant's office in India. Narra had allegedly confronted her husband about Ajit: Rao allegedly told his wife there was no harm in an extramarital affair.

Bewley told **India-West** he could not state whether Rao and Ajit were under investigation. He also could not state whether there was any new information on how Rao entered the apartment that night or whether Ajit was in the U.S. at the time, saying the release of such information would

compromise the integrity of the investigation.

Both Rao and Ajit were questioned by police after Sasikala and A REDACTED bodies were found. The Telugu Association of North America raised funds to have their bodies returned to Vijayawada for the final rites.

Rao did not attend the funeral of his wife and son, though his passport had not been confiscated (see earlier India-West story **here**).

TALK OF THE TOWN

Sikh Asylum Seekers Allegedly Tortured at ICE Detention Facility in Georgia

3 comments 62%

Nation Mourns Vajpayee's Death: 'India Has Lost a Great Son'

2 comments 60%

Jaya Prada Makes Small-Screen Debut in &TV's New Offering

Priyanka Chopra-Nick Jonas Enjoy a Dinner Date in Mumbai

EXHIBIT E

Prudential

The Prudential Insurance Company of America
Pruco Life Insurance Company of New Jersey
Pruco Life Insurance Company
All are Prudential companies.
http://LifeInsurance.Prudential.com

Life Insurance Claim Form

GETTING STARTED: If you have any questions about completing this form, please refer to the instructions that begin on page 5 or contact us at 800-496-1035.

It's Prudential's responsibility to contact all named beneficiaries on the policies provided.

REMEMBER: Each beneficiary must complete and submit a separate claim form. Only one death certificate with a raised state seal is needed.

[redacted]

Hanumantharao Narra
Name (First, Middle, Last)

5090 Beatty St
Street Address — Apt/Suite (optional)

Piscataway NJ 08854
City, State, Zip

Home phone — 856 236 4402 Mobile phone — Email address

Husband — REDACTED — 1979 — REDACTED
Relationship to deceased — Date of birth (mm/dd/yyyy) — SSN, TIN or EIN

See page 5 of the instructions for the information regarding the appropriate TIN or EIN.

I am the (check one):

- [x] Beneficiary - Person named to receive funds from the policy
- [ ] Power of Attorney for beneficiary (Attach Power of Attorney documentation)
- [ ] Representative of the Insured's estate (Attach a copy of proof of appointment)
- [ ] Trustee (Attach a copy of the trust agreement) Name of trust _____
  - [ ] Check if you are the sole trustee of a (ir)revocable trust, the trust can own/withdraw funds from life insurance policy, the trust is not a testamentary trust and the Alliance Account is the payment option selected.
  - [ ] Check if any beneficiaries are considered a "skip person" by the Internal Revenue Code. See instructions for more information.
- [ ] Legal guardian for the beneficiary (Attach a copy of the court order naming you as guardian) *If the beneficiary is a minor provide minor's name and date of birth.*

First name — MI — Last name — Date of birth (mm/dd/yyyy)

- [ ] Assignee (Specify amount you are claiming) _____
- [ ] Other (Please specify) _____

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Pruco Life Insurance Company of New Jersey
Pruco Life Insurance Company
All are Prudential companies.
http://Lifeinsurance.Prudential.com

Life Insurance Claim Form

2. About the Deceased

Provide information about the deceased. If you're not aware of any other names, leave that line blank.

Saeikala Narra
Name (First, Middle, Last)

In order for us to identify additional policies, provide any other names by which the deceased may have been known (e.g., name changes)

REDACTED 1978
Date of birth (mm/dd/yyyy)

03/23/2017
Date of death (mm/dd/yyyy)

3. About the Policy

Provide all the policy number(s) for which you are making a claim. The policy number(s) will be an 8- or 9-digit number and may include letter prefixes (e.g., X12345678)

Policy number(s)	V2353442	L9201428	
Policy number(s)			
Policy number(s)			

4. How to Receive Your Funds

In order to meet your specific needs, we offer several payment options for you to receive your life insurance death benefits.

Most Prudential policies offer several payment and settlement options that you should consider before making any election. If you would like detailed information about those options, please see pages 6-8 of this form or contact your Prudential Representative or customer service office at 800-496-1035. We also understand that this may be an emotionally challenging time in life and making financial decisions can seem overwhelming. To help make one decision easier for you, your eligible death claim benefits will be paid by the way of the Alliance Account (unless you elect an alternative payment or settlement option), where your money will earn interest until you're ready to make decisions about how to use the funds. For complete information and eligibility details about the Alliance Account, read pages 6 and 7 of this form. The minimum interest rate that will be paid on the Alliance Account will be no lower than 0.5% and may be as high as 3.5%. (The current rate, as of the date this form was mailed to you, is 1.50 %.) This rate may differ if you already have an existing open Alliance Account. The higher rate will prevail.

If you would like to select an alternative option, including a single lump sum check, indicate it here (as described in Understanding Your Options on Page 8 of the Instructions). Write your selection below:

For the Alliance Account settlement option, described on pages 6 and 7, please leave this line blank.

NOTE: You can also pay the funeral home directly. *You must attach a copy of the funeral home assignment with this form to do so. Any remaining proceeds will be applied based on your selection above.*

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Prudential

The Prudential Insurance Company of America
Pruco Life Insurance Company of New Jersey
Pruco Life Insurance Company
All are Prudential companies.
http://LifeInsurance.Prudential.com

Life Insurance Claim Form

4. How to Receive Your Funds (continued)

Beneficiary Designation (for Alliance Account or other payment option)
Please complete the following if you selected a payment option other than the single lump sum check above. Any amount that remains payable upon your death will be paid to those below. If you do not designate any beneficiaries, or if all beneficiaries predecease you, any balance will be paid to your estate. NOTE: If the Alliance Account was selected as the payment option and will be owned by a Trust, a beneficiary cannot be named for the account. Successor Trustees must be named in the Trust Agreement

Choose One:

☒ Pay my estate

☐ Pay beneficiary(ies) (Provide beneficiary information below)

Primary Beneficiary

Name (First, MI, Last) | Date of birth | SSN, TIN or EIN

Address

Relationship to you | Telephone | Email address

Beneficiary 2

☐ Primary (%_____) ☐ Contingent (Contingent beneficiary will be paid if no primary beneficiary survives the insured.)

Name (First, MI, Last) | Date of birth | SSN, TIN or EIN

Address

Relationship to you | Telephone | Email address

5. Tax Withholding Election (Applicable for qualified plan distributions)

Complete this section if you would like taxes withheld. If you do not make any elections, we will withhold taxes unless required by law. Other alternatives and settlement options may require other tax forms, if needed, these will be sent to you.

☐ Withhold federal income taxes from the taxable portion of the payment.

☐ Withhold state income taxes from the taxable portion of the payment.

For additional information, see the Tax Withholding Election Information section in the Instructions and Disclosures on page 5.

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Prudential

The Prudential Insurance Company of America
Pruco Life Insurance Company of New Jersey
Pruco Life Insurance Company
All are Prudential companies.
http://Lifeinsurance.Prudential.com

Life Insurance Claim Form

6. Tax Certification

Please complete any applicable portions of (a) or (b) below. Make sure you have included your SSN/TIN in Section 1.

(a) Under penalties of perjury, I certify that:
- I am a U.S. person (including resident alien);
- *The Social Security/Tax Identification Number provided in "Section 1. About You" on this form* is my correct SSN/TIN;
- I am not subject to FATCA reporting; and
- I am not subject to backup withholding due to failure to report interest or dividend income (see "Backup Withholding" in the Tax Certification section).

If you are subject to FATCA reporting or if you have been notified by the Internal Revenue Service that you are subject to backup withholding due to failure to report interest or dividend income, check the applicable box below:
- ☐ I am subject to FATCA reporting
- ☐ I am subject to backup withholding due to failure to report interest or dividend income

(b) I am not a U.S. person (including resident alien). I am a citizen of _____.
Attach the applicable IRS Form W-8 (BEN, BEN-E, ECI, EXP, IMY).

7. Authorization to Release Information

I authorize Prudential or its authorized representatives to disclose policy and benefits information, including but not limited to the claim status and the amount of insurance benefit proceeds, in its explanation of benefits to beneficiaries, funeral home representatives, and assignees of the insurance benefits or in response to inquires from these individuals. For the purpose of processing and payment of claims in an efficient and prompt manner, I authorize Prudential to consolidate and disclose completed claim forms and documents to appropriate associates for each and every one of Prudential Financial, Inc.'s affiliates or business units for which a claim for payment or distribution is made.

8. Signature

I have read and agree to sections 1 through 7 and the Claim Fraud Warnings included in this form on page 9. By signing this form, I certify that information that I have provided is true and complete. I understand that there may be tax implications as a result of this request.

FLORIDA RESIDENTS - Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a *statement of claim or an application containing any false, incomplete or misleading information* is guilty of a felony of the third degree.

NEW YORK RESIDENTS - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for purpose of misleading information concerning any fact material there to, commits a fraudulent insurance act, which is a crime and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

The Internal Revenue Service does not require your consent to any provision in this document other than the certifications required to avoid backup withholding.

[signature] — Beneficiary's or Claimant's signature

05/07/2017 — Date (mm/dd/yyyy)

To be completed by Prudential Representative

☑ Check here to select Field Office Delivery

Representative's Name	Telephone Number	Contact Number	Field Office Code
Daniel Linn	908-770-8521	908-770-8521	TRNL

Address to deliver proceeds (only needed if private or detached office)
1 Tower Center 16th Floor East Brunswick NJ 08872

Complete and return this page.
COMB 388 NJ Ed. 2/2017

Sasikala Narra

CASAHFQ3H2V-02

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05092017 10:46 SCANNER13 1 0 888

Prudential

The Prudential Insurance Company of America
Pruco Life Insurance Company of New Jersey
Pruco Life Insurance Company
All are Prudential companies.
http://LifeInsurance.Prudential.com

Life Insurance Claim Form

4. How to Receive Your Funds (continued)

Beneficiary Designation (for Alliance Account or other payment option)
Please complete the following if you selected a payment option other than the single lump sum check above. Any amount that remains payable upon your death will be paid to those below. If you do not designate any beneficiaries, or if all beneficiaries predecease you, any balance will be paid to your estate. NOTE: If the Alliance Account was selected as the payment option and will be owned by a Trust, a beneficiary cannot be named for the account. Successor Trustees must be named in the Trust Agreement.

Choose One:

☐ Pay my estate

☑ Pay beneficiary(ies) (Provide beneficiary information below)

Primary Beneficiary

Name (First, MI, Last)	Date of birth	SSN, TIN or EIN
Harsha Tharan Narra	1979	REDACTED

Address

Relationship to you	Telephone	Email address

Beneficiary 2

☐ Primary (%_____) ☐ Contingent (Contingent beneficiary will be paid if no primary beneficiary survives the insured.)

Name (First, MI, Last)	Date of birth	SSN, TIN or EIN

Address

Relationship to you	Telephone	Email address

5. Tax Withholding Election (Applicable for qualified plan distributions)

Complete this section if you would like taxes withheld. If you do not make any elections, we will not withhold taxes unless required by law. Other alternatives and settlement options may require other tax forms, if needed, these will be sent to you.

☐ Withhold federal income taxes from the taxable portion of the payment.

☐ Withhold state income taxes from the taxable portion of the payment.

For additional information, see the Tax Withholding Election Information section in the Instructions and Disclosures on page 5.

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05092017 10:45 SCANNER13 1 0 286

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Pruco Life Insurance Company of New Jersey
Pruco Life Insurance Company
All are Prudential companies.
http://LifeInsurance.Prudential.com

Claim Fraud Warnings

For residents of all states and jurisdictions except Alabama, Arizona, California, the District of Columbia, Florida, Kentucky, Louisiana, Maine, Maryland, New Hampshire, New Jersey, New York, North Carolina, Pennsylvania, Puerto Rico, Rhode Island, Texas, Utah, Vermont, Virginia, and Washington: WARNING -- Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for purpose of misleading, information concerning any fact material thereto.

ALABAMA RESIDENTS -- Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof

ARIZONA RESIDENTS -- For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA and RHODE ISLAND RESIDENTS -- Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA and TEXAS RESIDENTS -- For your protection, California and Texas law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

KENTUCKY RESIDENTS -- Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime

MAINE and WASHINGTON RESIDENTS -- Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company commits a crime. Penalties include imprisonment, fines, and denial of insurance benefits.

MARYLAND RESIDENTS -- Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW HAMPSHIRE RESIDENTS -- Any person who, with purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20

NEW JERSEY RESIDENTS -- Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NORTH CAROLINA RESIDENTS -- Any person who, with the intent to injure, defraud, or deceive an insurer or insurance claimant, presents or causes to be presented a written or oral statement, as part of, or in support of, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains false information concerning a fact or matter material to the claim may be guilty of a Class H felony

PENNSYLVANIA and UTAH RESIDENTS -- Any person who and with intent to defraud any insurance company or other person files an application for insurance or statement containing any materially false information or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties

PUERTO RICO RESIDENTS -- Any person who knowingly and with the intention of defrauding presents false information in an insurance application or presents, helps, or cause the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

VERMONT RESIDENTS -- Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

VIRGINIA RESIDENTS -- Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Do not return this page with completed form.
COMB 388 N1 Ed 2/2017

Prudential

The Prudential Insurance Company of America
Pruco Life Insurance Company of New Jersey
Pruco Life Insurance Company
All are Prudential companies.
http://LifeInsurance.Prudential.com

Quick Start Guide

What you'll find in this package

- *Life Insurance Claim Form* -- Please complete, sign and return this form to start the claim process.
- *Alliance Account information* -- We also explain this flexible, convenient option for receiving your claim proceeds throughout the package

Note: On these pages, *I*, *you*, and *your* refer to the person making the claim. *We*, *us*, and *our* refer to the Prudential company that issued the policy.

To submit your claim, follow these steps:

1. Decide how to receive your funds

Be sure to select a payment option when you complete the form. Your options include:

- Open an interest-bearing Alliance Account that offers immediate access to your funds together with draft-writing privileges. When your claim is paid by way of the Alliance Account, you can take as much time as you need to consider important financial decisions, while earning interest. Additionally, accessing your funds is as simple as writing a draft to yourself or anyone else. (Certain businesses may have their own policies and procedures for accepting drafts.) The account begins earning interest from the day it is opened. You can leave the funds in your account for as long as you like, access any or all of your funds, and transfer funds to another available settlement option at no cost and at any time. Read more about the Alliance Account on pages 6-7 of the Life Insurance Claim Form for more information.
- Elect to receive a single lump sum check by mail.
- Select another payment option as described on page 8 of the form. If you would like more information on the payment options available to you, please call 800-496-1035 to request the *Your Options* brochure.

Note: You can also use proceeds to pay the funeral home directly. You must submit a copy of the funeral home assignment with the claim form to do so.

2. Complete the enclosed form

Fill out the enclosed *Life Insurance Claim Form* that begins on the next page. Please follow the instructions and provide all requested information for prompt claim processing.

3. Return the signed claim form and supporting documentation

Please mail pages 1-4 of your claim form, as well as any additional documents that may be required, including a death certificate with a raised state seal to:

Regular mail	Express mail
Prudential	Prudential
Attention: Life Claims	Attention: Life Claims
P.O. Box 7074	2101 Welsh Road
Philadelphia, PA 19176	Dresher, PA 19025

What to expect after submitting your form

We're committed to processing your claim as quickly as possible. Once we receive and verify all your information, we're typically able to process a claim within 5-7 business days.

EXHIBIT F

OFFICE OF THE PROSECUTOR
COUNTY OF BURLINGTON
PO BOX 6000
MOUNT HOLLY, NEW JERSEY 08060
PHONE (609) 265-5035
www.burlpros.org

Scott A. Coffina
BURLINGTON COUNTY PROSECUTOR

Phillip Aranow
FIRST ASSISTANT PROSECUTOR

DARREN ANDERSON
CHIEF OF INVESTIGATIONS

To: Mary Kelly- Prudential Life Insurance

From: Assistant Prosecutor Robert S. Van Gilst

Ref: Sasikala Narra Policy # V2 353 442, L9 201 428

Date: 05/31/2017

To Whom It May Concern:

This letter shall serve as notification that as of this date, that the death of Sasikala Narra is an open criminal investigation therefore no parties can be conclusively eliminated at this time.

Sincerely,

Assistant Prosecutor Robert S. Van Gilst

Burlington County Prosecutor's Office

Major Crimes Unit Supervisor